Instructions for submitting a West Virginia Prior Authorization Form

For Medical Providers

To submit a West Virginia prior authorization form electronically, providers must register for access to Cigna's online prior authorization tool.

To initiate registration for the tool, send an email to PMAC@Cigna.com. Include the following information with your submission:

- Provider or facility name
- Mailing address
- Email address
- Contact name
- Contact telephone number

If you prefer to submit a prior authorization form via fax, please send it to **866.873.8279**.

To contact Cigna's Coverage Review Team, please call the phone number listed on the back of the customer's ID card or 800.Cigna24 (800.244.6224).

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West Virginia prior authorization form
Medical

Common Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) requiring prior authorization:

- Bariatric procedures (CPT codes 43842 - 43848)
- Spinal procedures (CPT codes 22552, 22554, 22558, and 22630 - 22634)
- Speech therapy (CPT code 92507)
- Varicose vein procedures: including sclerotherapy, radiofrequency ablation, and phlebectomy (CPT codes 36468 - 36479 and 37700 - 37785)
- Certain types of genetic testing (CPT codes 81161 - 81479)
- Any inpatient services

DIRECTIONS:
To submit a prior authorization using this form, print and complete all fields with the required information and fax to Cigna at 866.873.8279. Please attach any supporting clinical documentation with your fax submission.

For a full list of services that require prior authorization, including online guidelines and documents used to make this decision, please visit the Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > Forms Center > Medical Forms. You can click on Coverage Policies to view current coverage policy information.

General information

Patient name	
Patient date of birth	
Patient Cigna ID number	

Submitter name	
Submitter telephone number	

Service details

Name of service or durable medical equipment (DME) requested	
CPT or HCPCS codes requested (please indicate left, right, or bilateral, if applicable)	
Diagnosis (ICD-10 code, if available)	
Please indicate if the service is for inpatient, outpatient, or (DME)	
Date of service, if available (please indicate if service is currently unscheduled)	
Number of visits or units requested (if applicable)	

Provider details

Note: Please include the provider requesting and performing the service, as applicable. If requesting provider is the same as the servicing provider, please indicate "same" in the applicable fields for servicing provider. If there will be an assistant surgeon, please include the provider's detail with your submission.

Requesting provider name	
Requesting provider telephone number	
Requesting provider Taxpayer Identification Number (TIN), if available	
Requesting provider address	
Servicing provider name	
Servicing provider telephone number	
Servicing Provider TIN, if available	
Servicing provider address	

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